**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
MILLENNIUM CHIROPRACTIC

**Respondent Name**
EAST TX EDUCATIONAL INS ASSN

**MFDR Tracking Number**
M4-14-3297-01

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
JULY 2, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier is denying our New Patient Evaluation on **7/25/13** based on unnecessary medical treatment. How can we possibly create a treatment plan that is designed to treat 'identified problems', if we were not allowed to perform an initial evaluation on the patient's first visit to our clinic? It is mandated that such evaluation be made for each patient per the following guidelines: (*6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed*. The patient was assessed and demonstrated compliancy with our recommended treatment plan. However, she was unable to reach our objective goals and orientation into a CPM program was made. THIS WAS APPROVED BY THE CARRIER, INDICATING THAT FURTHER TREATMENT WAS NECESSARY, AND ALL PREVIOUS TREATMENT SHOULD BE APPROVED AS WELL—AS MEDICAL NECESSITY WAS SHOWN AND PROVEN AS TREATMENT WAS AUTHORIZED. PLEASE NOTE THAT THE PATIENT WAS APPROVED FOR (3) SEPARATE SESSIONS OF CHRONIC PAIN MANAGEMENT BY THE INSURANCE CARRIER—WHICH SHOWS THE MEDICAL NECESSITY FOR TREATMENT…Additionally, The service rendered on 7/29/13 (cpt 90791) which the carrier denied based on the denial code (29), as listed above, has been incorrectly denied. This bill was submitted to the carrier as a corrected claim, not a new billing. There was no change in date of service, diagnosis, or even documentation. Our original bill was submitted to the carrier timely with proper documentation, and the correct claim then followed with the exact same documentation, indicating that no new service was rendered. This correct claim can not be denied based on untimely filing."

**Amount in Dispute:** $642.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "We have reviewed these services and find that date of service 7/25/13 was initially received on 8/12/13. This office visit was referred for retrospective review, in which this service was determined non certified based on Official Disability Guidelines. The patient's sprain/strain whoosh have resolved within 6 to 8 weeks with conservative treatment, and there were no further treatment recommendations for this work injury of 2/15/08. Denial was issued on 9/5/13. We received this bill again on 10/2/13, 3/5/14 and 4/7/14. The original determination was maintained on each of these received dates.

The Psychiatric Diagnostic Interview occurred on 7/29/13 was received by us on 8/13/13 and this bill was also sent for retrospective review. This service was non-certified based on Official Disability Guidelines as it was determined that based on the work injury of sprain/strain, all symptoms should have resolved by 4/15/08. Any further treatment would be related to the claimant's ongoing and pre-existing condition of degenerative spine disease. Denial based on retrospective review was issued on 9/15/13.

Please note that the original bill for date of service 7/29/13 was coded with CPT code 90801. On 1/13/14 we received date of service 7/29/13 with CPT code 90791. This bill was denied due to timely filing. On 3/5/14 we received a reconsideration indicating the CPT code had been changed from 90801 to 90791."

**Response Submitted by:** Claims Administrative Services, Inc.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 25, 2013 | CPT Code 99204-25<br>New Patient Office Visit | $342.00 | $0.00 |
| July 29, 2013 | CPT Code 90791 (X12)<br>Psychiatric Diagnostic Evaluation | $300.00 | $0.00 |
| TOTAL | | $642.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009 outlines the medical bill submission procedure.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
5. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216-Based on findings of a review organization.
   - 723-Based on a utilization review determination, these charges are denied as not medically necessary and appropriate.
   - 29-The time limit for filing has expired.
   - 719-Per rule 133.20, a medical bill shall not be submitted later than the 95$^{th}$ day after the date of service.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 350-Bill has been identified as a request for reconsideration or appeal.

**Issues**

1. Was the original bill for services rendered on July 29, 2013 submitted timely?
2. Does a medical necessity issue exist for services rendered on July 29, 2013?
3. Does a medical necessity issue exist for services rendered on July 25, 2013?
4. Are the disputed services eligible for medical fee dispute resolution?

**Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 90791 rendered on July 29, 2013, based upon reason code "29" and "719."

   28 Texas Administrative Code §133.20(b), "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   The requestor contends that reimbursement is due because "This bill was submitted to the carrier as a corrected claim, not a new billing. There was no change in date of service, diagnosis, or even documentation. Our original bill was submitted to the carrier timely with proper documentation, and the correct claim then followed with the exact same documentation, indicating that no new service was rendered. This correct claim can not be denied based on untimely filing."

   To determine if the subsequent bill was a new bill or a corrected bill, the Division refers to 28 Texas Administrative Code §133.20(c) and (g).

- 28 Texas Administrative Code §133.20(c) states "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."
- 28 Texas Administrative Code §133.20(g), "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."

A review of the submitted documentation finds that the requestor originally billed CPT code "90801– Psychiatric diagnostic interview examination" timely in accordance with 28 Texas Administrative Code §133.20(b). CPT code 90801 was audited and denied based upon reason codes "216" and "723." Therefore, this was a complete bill.

On the subsequent bill dated January 9, 2014, the requestor noted that it was a "Corrected Claim" and billed CPT code "90791- Psychiatric diagnostic evaluation" (non-medical). This bill was processed by the insurance carrier as a new bill and denied based upon reason code "29" and "719."

On the original bill, the requestor used code 90801 that was deleted effective January 1, 2013. CPT code 90801 was replaced with codes "90791"(non-medical) and "90792"(medical). The Division finds that the requestor corrected the coding error and used the appropriate code on the subsequent bill. Because the code used replaced the code billed, this was a corrected bill not a new bill.

The Division concludes that the original bill was submitted timely in accordance with 28 Texas Administrative Code §133.20(b).

2. According to the original explanation of benefits, the respondent denied reimbursement for the disputed services rendered on July 29, 2013 based upon reason codes "216" and "723." As stated above by the requestor, "There was no change in date of service, diagnosis, or even documentation. Our original bill was submitted to the carrier timely with proper documentation, and the correct claim then followed with the exact same documentation, indicating that no new service was rendered." The Division finds that the requestor corrected the coding error from 90801 to 90791; however, the disputed service was denied by the respondent based upon not medically necessary.
3. According to the explanation of benefits, the respondent denied reimbursement for the disputed office visit, CPT code 99204-25 and Psychiatric Diagnostic Evaluation - 90801 (90791), based upon reason codes "216" and "723."

   28 Texas Administrative Code §133.305(a)(5) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021." 28 Texas Administrative Code §133.307(f)(3)(B) states "The division may dismiss a request for MFDR if: (B) the request contains an unresolved adverse determination of medical necessity." The appropriate dispute process for unresolved issues of medical necessity is pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that a medical necessity issue exists, therefore, the dispute was not filed in accordance with 28 Texas Administrative Code §133.305 and §133.307.
4. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 08/28/2014 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.